SURGERY

UNDER THE CHARGE OF
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A Procedure for Wide Extirpation of Cancer of the Prostate.— Gayet, Champel, and Fayol (*Jour. d'Urolog.*, 1913, iii, 333) say that up to the present time three perineal paths have been employed for the removal of a cancerous prostate. These they designate as the anterior, middle, and posterior. The anterior is through the anterior triangle of the perineum. In the middle, which is more frequently employed, a transverse incision is made between the two tuberosities of the ischium. In the posterior the incision is made from the tuberosity of the ischium to the coccyx. Gayet, Champel, and Fayol utilize the whole length of the perineum, the incision passing well to the left side of the anus. The following is a brief outline of the operation which they describe: The patient is placed in the lateroventral decubitus or the pelvis may be extremely elevated so that the perineum looks toward the ceiling. The incision which passes from the root of the penis to the coccyx is deepened and the rectum separated and pushed posteriorly. The posterior surface of the prostate, the seminal vesicles and the posterior inferior surface of the bladder are then exposed. If the lateroventral position has been employed, this is now changed to the dorsal with extreme elevation of the pelvis. The perineal floor is now divided in its whole length and the rectum is pushed further backward and to the right side. The finger recognizes the apex of the prostate and membranous urethra which is easy if a sound or catheter has been placed in the urethra. The urethra is opened in front of the apex of the prostate and through this opening an elbowed retractor is introduced. The urethra is divided transversely in its whole circumference and the prostate is separated from the surrounding structures by scissors, the hemorrhage being controlled by a gauze tampon. If the prostate can be depressed far enough, a puncture is made by a bistoury through the anterior wall of the bladder above the portion invaded by the tumor. This opening is enlarged on both sides by scissors, giving a wide opening into the bladder. The posterior portion of the bladder in the region of the trigone and ureters is now well exposed. With catheterization of the ureters, the rest of the separation of the prostate and tumor can be completed under the guidance of the eyes. The separation of the divided ends of the urethra and bladder is considerable, but their elasticity aided by a moderate liberation of the urethra permits them to be brought together by sutures. But it is not necessary to suture them together in their whole circumference, a large opening in the bladder being left posteriorly. Through this opening a large tube is passed and fixed in position with a catgut suture. The muscles of the perineum are then restored very incompletely and a large drain is introduced penetrating to the side of the vesical tube. The skin margins are then brought together, leaving a large median opening for gauze drainage. The results of this operation in two cases were benign. At the end of five weeks in the first patient all urine passed in the natural way and in the second patient more quickly, without the necessity of catheterization or dilatation.

Traumatic Epilepsy after Head Injuries in the Japanese-Russian War.—EGUCHI (*Deutsch. Zeitschr. f. Chir.*, 1913, cxxi, 199) says that head injuries frequently produce traumatic epilepsy. From 1.3 to 4.7 per cent., on the average 3 per cent., of all skull injuries admitted to the reserve hospitals of Japan during the war were followed by traumatic epilepsy. In these, injuries of the bone and dura mater produced irritation of the brain. Wounds of the soft tissues alone gave no cases of epilepsy. The symptoms followed not only injuries of the cortex in the motor area, but many times injuries in other areas. The traumatic epilepsy appears usually after cicatricial tissue develops, Its occurrence at an earlier stage is very rare. It was more frequent after sagittal than after transverse gun-shot wounds. The frequency was in proportion to the size of the brain injury. The autopsy did not show in any case any changes in the medulla, pons, or cerebellum. Scars of the head are very irritable in cases of traumatic epilepsy, and are very tender on palpation. If a bone defect is covered only with a flap of soft tissues, the pulsation of the brain can be seen. The soft tissue flap used corresponded to that of Kocher. Adhesions between the dura or skin and the brain frequently produce epilepsy, as does traumatic new formation, such as thickening of the inner table of the skull, cysts, abscesses, etc. Foreign bodies, pieces of bone, and in war especially, splinters of bone or pieces of missiles, cause epilepsy by pressure on the dura and brain. All of Eguchi's cases developed a nervous disposition. Epilepsy develops easily after head injuries in nervous people. The shortest period from the day of the injury to the beginning of the epilepsy was 3 days, the longest was 442 days, the average 161 days. Medicines, especially the bromides, cannot suppress the attacks before operation, but after operation has been done the attacks, which recur in some cases, can be more quickly controlled by the bromides. Operation gave good results in Eguchi's cases. A cure was obtained in 11 cases, or 90.9 per cent., and no results in 1 case, or 9.1 per cent. The death in this last case was not the result of the operation, but of the bursting of an aneurysm. In all of the other cases no attack had occurred two years after operation. One should operate on all cases of traumatic epilepsy from head injuries in which he detects scars, or wounds, or other changes. If the epilepsy developed a short time before the operation, a quick result should be expected. If the attacks have been occurring for a much longer period, the operation may be followed by several attacks.